DOCUMENT RESUME

ED 294 404 EC 202 575

AUTHOR Goff, Pamela L.; Hemmesch, Henrietta E.
TITLE Project KIT (Kids in Transition) Educators Resource Book: A Process of Planning for Change. Revised.
INSTITUTION Northern Trails Area Education Agency. Clear Lake, Iowa.
PUB DATE Sep 87
NOTE 80p.; Prepared by the Division of Special Education. For a related document, see EC 202 576.
PUB TYPE Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC04 Plus Postage.
DESCRIPTORS *Cooperative Planning; Daily Living Skills; *Disabilities; Early Childhood Education; Educational Planning; Intervention; *Parent Participation; *Parent School Relationship; *Parent Teacher Cooperation; Skill Development; Special Education; Teaching Methods; *Transitional Programs

ABSTRACT

Project KIT (Kids in Transition) of the Northern Trails Area Education Agency in Iowa assists in preparing for children's transition from early childhood special education programs to elementary regular/special education programs and transition from special education home intervention services to the preschool special education classroom. This educators' guide describes the project's planning process, implemented by the parent/child and the receiving school's staff through meetings, timetables, and conferences. Detailed timetables are presented, along with a form for sending and receiving teachers to record information observed during program visitations. "Transition and the Receiving Teacher" provides tips from an experienced receiving kindergarten teacher; lists skills needed to enter kindergarten; and outlines strategies for teaching kindergarten survival skills in the areas of self-understanding, communicating, task completion, school and classroom rules and routines, and self-help. "Transition and the Parent" lists guidelines for developing effective parent-teacher communication, and includes an article reprint on improving home-school communication through sharing of daily reports and an observation form for parents to use in assessing the child's classroom situation. Appendices contain definitions of handicapping conditions and other special education terminology, as well as lists of useful books, films/videos, and toll-free telephone numbers. (JDD)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED294404

KIDS IN TRANSITION (K.I.T.)

A Process of Planning for Change

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☒ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

EDUCATORS RESOURCE BOOK

Authors:

Pamela L. Goff, Teacher of Early Childhood Special Education
Northern Trails Area Education Agency
Clear Lake, Iowa 50428

Henrietta E. Hemmesch, MSW, ACSW, School Social Worker
Rochester Public Schools
Rochester, Minnesota 55902
Northern Trails Area Education Agency
School Social Worker 1977-1986

Contributors:

Margaret J. Jensen,
NTAEA Teacher of Early Childhood Special Education
Marian Lenz,
Garner-Hayfield School District, Kindergarten Teacher
Mary Schertz,
NTAEA Supervisor Early Childhood Special Education

EC 302575

NTAEA
Special Education Division
Northern Trails Area Education Agency
Box M Clear Lake, IA 50428
Telephone: (515)357-6125

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Mary E. Schertz
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

BEST COPY AVAILABLE

Project KIT has been funded with Part B, E.H.A.; P.L. 94-142 funding. Permission to duplicate this publication for non-profit use is granted by Northern Trails Area Education Agency (NTAEA), contingent upon NTAEA and the authors and contributors being given credit for its development. No portion of this document may be used for commercial publication without the written permission of Northern Trails Area Education Agency, Division of Special Education, Early Childhood Special Education Department, Box M, Clear Lake, Iowa 50428.

First Printing: August, 1986
Revised: September, 1987

Introduction

to the

KIDS IN TRANSITION EDUCATORS NOTEBOOK

This notebook has been developed to provide educators with a guide to special education information and procedures. It can be useful when preparing for children's transition from early childhood special education (ECSE) programs to elementary regular/special education programs. In addition, it addresses the transition from special education home intervention services to the preschool special education classrooms.

We hope this notebook will serve as a valuable resource in your classroom.

We wish to thank Northern Trails Area Education Agency and the Iowa Department of Education for making the time and funding possible for this project. A special thank you to Julie Curry, Technical Assistance Network, funded by the Department of Education, for her assistance.

TABLE OF CONTENTS

Page

Introduction
- Kids in Transition: A Process of Planning for Change . 1
- Kids in Transition and the Iowa Model 2

I. Transition--A Process of Change
- The Objective of Transition Planning 3
- Preparing for Successful Transition from the Home Instruction to Early Childhood Center-Based Special Education Programs. Transition Planning Timetable 4
- Preparing for Successful Transitions from Early Childhood Special Education Programs to School-Age Programs. Transition Planning Timetable 6
- Importance of Program Visitation 9
- Teacher's Observation Sheet for Program Visitation . . . 10

II. Transition and the Receiving Teacher
- Teacher to Teacher 14
- What Does a Special Education Student Need for Kindergarten? 16
- Strategies for Teaching Survival Skills 17
- Preparing Regular Classroom Peers 38
- Reports, Reports, Reports, Now What? 39

III. Transition and the Parent/s
- Teachers Communicating with Parents 40
- Home-School Communication 42
- Daily Report Cards 43
- Parent Observation Sheet for Program Visitation 44

Appendix
- Definitions of Handicapping Conditions 46
- Terminology Used in the Field of Special Education . . . 52
- Books Regarding Handicaps for Use in the Classroom . . . 62
- Films/Videos Regarding Handicaps 64
- National Toll-Free Telephone Numbers 67

Kids In Transition: A Process of Planning for Change (K.I.T.)

A critical component of a successful transition is preparing children and their families to adjust to future educational placements. One transition may be from special education home instruction programming to a preschool classroom. Another transition may occur when the chid leaves the preschool classroom to attend regular/special education settings. Another component is to assist preschoolers in generalizing acquired skills to other environments.

The involvement of family members; parents, the child and siblings, as active participants in transition planning is an important factor in developing successful transitions for handicapped preschoolers. By approaching educational transitions from the perspective of the family system as well as from the school system, appropriate educational decisions for the needs of the child and family can be made more effectively.

To ensure a smooth adjustment, Project KIT formalizes a planning process for transition of handicapped preschoolers. The planning process includes two components, one which provides transition preparations for the parent/child, and one for the receiving school's staff. These preparations are implemented through a series of parent meetings, transition timetable, special education conference meetings, and inservices/planning meetings for receiving teachers.

K.I.T. would be appropriate for Early Childhood Special Education programs to use when planning an educational transition for an identified handicapped student. K.I.T.'s planning process can be implemented by early childhood special education teachers, special education support staff or, ideally, a combination of both a teacher and a support staff member.

It is the hope of the project developers that "Kids In Transition" will facilitate effective transitions for all children and families.

Kids In Transition and the Iowa Model

To facilitate a better understanding of Project KIT, we will present a brief overview of Iowa's early childhood special education service delivery model.

In the mid-1970s, national and state legislation had a profound effect on Iowa's special education service delivery model. The national legislation was PL 94-142. In the state of Iowa, the monies resulting from PL 94-142 were targeted to the population below mandatory school age. In addition, state legislation established 15 Area Education Agencies (AEA) outlined on the map on page . Secondly, state legislation mandated services for children from birth who have an identified handicap. These services were to be provided by the AEAs. This mandate went one step beyond the mandates of PL 94-142, which was amended by P.L. 99-457 in 1986.

In Iowa, all early childhood special education programs are operated under the auspices of the Iowa Department of Education, Bureau of Special Education. As a result, all children identified and receiving services must meet the criteria as outlined in the Iowa Criteria for Preschool Handicapped.

The model most frequently used for children with special needs under the age of three years is the home instruction model, however this may vary according to the needs of each child. This model consists of home instruction teachers making regular visits to the child's home and working with both the child and the child's primary care givers. The second model is an early childhood special education center-based classroom which is a self-contained program. Children enter into this setting based upon need for services and meeting the state criteria. The center-based programs may be operated by the local school district or the area education agency.

Support services are made available to all home instruction and center-based programs. These support services include: school social workers, psychologists, audiologists, speech/language clinicians, nurses, consultants, occupational and/or physical therapists, adaptive physical education instructors, and teachers of the visually impaired and hearing impaired. These service providers are involved both in identification and special education instruction.

To assist service providers in implementing Project KIT, it may be helpful to compare your service delivery model with the Iowa model.

The Objective of Transition Planning

The objective of transition planning is to facilitate the process of moving a child from one educational setting to another. With transition planning, the process of change can be outlined through the use of a timetable with dates for completion of specific assignments and responsibilities. The use of a transition timetable promotes the use of a child planning team which includes the parent/s, early childhood special education staff, regular/special educators, and administrators from both the sending and receiving school districts. Additionally, a transition timetable can insure sufficient communication, planning, and parental involvement regarding an individual child's transition, which develops an effective home-school partnership.

The transition timetable is intended to be used by the child planning team. It recommends timelines and/or dates for completion of responsibilities. It also provides guidelines for exchanging appropriate information between sending and receiving programs, collecting assessment data, program visits and observations, conferencing, and placement.

In order to assist the child planning team in implementing the transition timetable, we recommend that the team identify a "transition coordinator" or case manager. This person would be responsible for coordinating the various program visits, conferences/staffings, and planning meetings.

The use of the transition timetable will facilitate a smooth passage from one educational setting to another.

Preparing for Successful Transition from Home Instruction to Center-Based Programs

Transition Planning Timetable

Step 1 Parents are informed that their child will be eligible in ___ months to attend a center-based program. Information regarding transition planning and the parents' role in planning (e.g., future meetings, school visits) is provided.

Step 2 School districts should be notified that a child/ren may be entering a center-based program in their district.

Step 3 Case manager informs support staff that child is eligible for center-based programming. Any additional assessments needed for a placement decision are identified.

Step 4 Pre-placement assessments are completed as needed.

Step 5 Informal transition conference is held to identify:

* potential placements
* special services required by the child
* transportation needs
* health needs
* relevant family needs

Individuals involved may include:

* parent
* receiving teacher/sending teacher
* speech and language clinician
* occupational therapist/physical therapist
* audiologist
* adaptive physical education teacher
* social worker
* nurse
* school principal
* school psychologist
* ECSE consultant

Tentative placement options are discussed, but not formalized. (At NTAEA the use of the "Summary of Special Education Conference" form is recommended).

Step 6 Case manager and parent discuss school preparation.

Step 7 Parents observe the receiving programs discussed as potential placements for their child; potential receiving teacher/s may wish to visit child's home.

Step 8 — Formal placement staffing is held with parents. NOTE: If out-of-district placement is being considered, please see procedure outlined in the NTAEA Special Education Manual.

Step 9 — If possible, child visits future program.

Step 10 — Records which are pertinent to the child's next placement should be identified. These records should be transferred to receiving program. Receiving program should make sure that staff significantly involved with child's new placement know about such records and have access to them.

Transition Follow-Up
(To be completed by sending teacher)

Week 1 — Talk with receiving teacher at end of the first week to check on child's adjustment and/or call the parent at the end of the first week to check on child's adjustment.

Week 1-6 — Arrange a standard time for a "check-up" phone call or visit. Discuss any problems or special needs that arise.

Week 6 — Informal transition conference is held to discuss child's current placement. This may include:

* parent
* receiving teacher/sending teacher
* speech and language clinician
* occupational therapist/physical therapist
* audiologist
* adaptive physical education teacher
* special education teacher (i.e., RM, SM, CC)
* social worker
* nurse
* school principal
* school psychologist
* ECSE consultant

At this time the receiving teacher becomes the case manager. Any/all concerns relating to the child should be directed to the case manager.

Adapted from Fowler, S.A. (1980). Transition to Public School. In K.E. Allen (Ed.) Mainstreaming in Early Childhood Education. Albany, NY: Kelmar Publishers.

Preparing for Successful Transitions from
Early Childhood Special Education Programs
to School-Age Programs

Transition Planning Timetable

Step 1 (Nov.-Jan.) Parents are reminded that child will be departing from preschool in ____ months to attend a new program. Information regarding transition planning and the parents' role in planning (e.g., future meetings, school visits) is provided.

Step 2 (Nov.-Jan.) School districts should be notified about number of children coming from the special education preschool. Names of children, description of handicapping condition and preschool program affiliation are sent.

Step 3 (Jan.-Feb.) Preschool staff complete a brief, initial progress report on child, based on IEP, identified handicap and current progress. Preschool staff identify what assessment data already are available and current regarding child.

Step 4 (Feb.-Mar.) Preschool staff meet with parents to share progress report and to add information from the parents regarding child progress. Assessment data, which may be useful for placement decisions are reviewed. Parent needs or concerns regarding the transition are assessed.

Step 5 (Feb.-Mar.) Member of preschool staff talks with student's resident school district superintendent or principal to share progress report and assessment information. Additional assessments needed for a placement decision are identified. AEA support staff responsible for conducting additional assessments are consulted.

Step 6 (Mar.) Pre-placement assessments are completed as needed.

Step 7 (Mar.-Apr.) Informal transition conferences are held to identify:

* potential placements
* special services required by child
* transportation needs
* health needs
* relevant family needs

Conference may include parent, preschool teacher, school district representative, and other support staff members.

Professionals who may be involved in a child's future placement are identified. For example:

* receiving teacher/sending teacher
* speech and language clinician
* occupational therapist/physical therapist
* audiologist
* special education consultant
* adaptive physical education teacher
* special education teacher (i.e., RM, SM, CC)
* social worker
* nurse
* school principal
* school psychologist

Tentative placement options are discussed, but not formalized. (At NTAEA the use the "Summary of Special Education Conference" form is recommended.)

Step 8 (Mar.-Apr.) Parent meeting on "Preparing Your Child for Kindergarten" is conducted by preschool staff. Preschool teacher and receiving kindergarten teacher plan a joint visit to child's home.

Step 9 (Apr.) Parents observe the receiving programs discussed as potential placements for their child; potential receiving teachers visit preschool special education program to observe child; and sending teacher visits potential receiving program.

Step 10 (Apr.-May) Formal placement staffing is held with parents. NOTE: If out-of-district placement is being considered, please see procedure outlined in the NTAEA Special Education Manual.

Step 11 (May) If possible, child visits future program. Sending and receiving teachers exchange visits, if they have not done so previously.

Step 12 (May) Records which are pertinent to the child's next placement should be identified. These records should be transferred to receiving program. Receiving program should make sure that staff significantly involved with child's new placement know about such records and have access to them.

Transition Follow-Up
(To be completed by sending teacher)

Week 1 Talk with receiving teacher at end of the first week to check on child's adjustment and/or call the parent at the end of the first week to check on child's adjustment.

Week 1-6 Arrange a standard time for a "check-up" phone call or visit. Discuss any problems or special needs that arise.

Week 6 Informal transition conference is held to discuss child's current placement. This may include:

* parent
* receiving teacher/sending teacher
* speech and languge clinician
* occupational therapist/physical therapist
* audiologist
* special education consultant
* adaptive physical education teacher
* special education teacher (i.e., RM, SM, CC)
* social worker
* nurse
* school principal
* school psychologist

At this time the receiving teacher becomes the case manager. Any/all concerns relating to the child should be directed to the case manager.

Adapted from Fowler, S. A. (1980). Transition to Public School. In K.E. Allen (Ed.) Mainstreaming in Early Childhood Education. Albany, NY: Kelmar Publishers.

IMPORTANCE OF PROGRAM VISITATION

Sending and receiving program staff need to have first-hand knowledge, understanding and appreciation for one another's programs. Accurate and up-to-date information helps staff assist parents and children with the transition to a new program and enhances the working relationship between the two.

Sending and receiving staff can be well-informed about the other's program as a result of visiting and utilizing the enclosed observation guide. Staff will know how to prepare children for a program change through curriculum and program planning. The information can also be used to help parents make placement decisions and to adapt to the change in program personnel.

TEACHER'S OBSERVATION SHEET FOR PROGRAM VISITATION

Child _____ DOB _____

Sending/Receiving Teacher _____

Site _____

Address _____

Phone Number _____

Date Observation Completed _____

CLASSROOM COMPOSITION AND WEEKLY SCHEDULE

1. What is the adult/child ratio?

2. How long do children attend school each day? How many days per week?

3. How often do children participate in activities outside of the classroom (music, art, library, etc.)? For how long? With what size group?

DAILY SCHEDULE

1. In considering schedules (attach) from both classes, how long do children spend?

   a. in large groups (singing, listening to stories, etc.)?

   b. in small groups?

   c. working on-on-one with an adult?

   d. working independently?

   e. doing academic and fine motor activities?

   f. in free play activities?

   g. in moving from one scheduled activity to another (lining up for recess, waiting to be called from large group to small group, etc.)?

   h. resting or napping?

   i. toileting? (number of times? how long?)

   j. eating lunch and/or snack?

PHYSICAL ARRANGEMENT OF CLASSROOM

1. Are the classroom and other areas used by the child barrier-free?

2. Is the classroom in an "open-space" with other classrooms or is it self-contained?

3. Are the bathroom and drinking fountain adjacent to the classroom or down the hallway?

4. Is all or part of the classroom carpeted?

5. Are work and play areas clearly separated?

6. Are play areas visible from work areas?

7. Do children work at tables, desks, or on the floor? If tables, how many children are at each table?

8. When in a group, do children sit on individual mats on the floor, on a group rug, in chairs, or elsewhere? If elsewhere, explain.

CLASSROOM RULES AND ROUTINES

1. Are children required to raise their hands? If so, when?

2. Are children encouraged to speak out? If so, when?

3. During what activities can children talk to their classmates and move freely about the room?

4. Do children have free or limited access to the bathroom, water fountain, pencil sharpener, supplies?

5. Do children manage all or some of their own materials (crayons, paper, paste) or do they use community materials? What materials do they manage? (Be specific.)

6. Do children walk in line single-file or double-file? Do they hold hands?

7. What kind of errands and chores are children expected to perform? What do they do independently? With other children? With adult assistance?

MOTOR SKILLS

1. What types of gross motor activities are children involved in (climbing jungle gym, group games such as Duck Duck Goose, running, etc.)?

2. What types of fine motor activities are children involved in (cutting, pasting, hold pencil, etc.)?

3. Are children expected to be independently mobile? With or without adaptive equipment?

4. Is adaptive Physical Education available? If so, from whom? Where?

SELF-HELP SKILLS

1. What dressing skills are children expected to accomplish independently (shoe tying, buttoning, zipping, putting on sweater or coat, pulling up pants, putting on mittens/gloves, etc.)?

2. What personal care skills are children expected to demonstrate (handwashing, toileting, nose care, etc.)?

3. What mealtime skills do children perform (getting own snack, carrying lunch tray, opening milk carton, drinking through straw, setting and cleaning table, etc.)?

COMMUNICATION

1. Are the children expected to verbalize their needs?

2. Are children expected to express ideas in large groups?

3. How are directions given to the child? How many directions are given at one time?

SOCIAL INTERACTION AND PLAY

1. Is the primary interaction in the classroom adult/child or child/child?

2. How do children typically initiate and respond to interaction with their peers? Verbally or physically?

3. What kinds of play materials are provided (puppets, sand table, bean bags, puzzles, crayons, etc.)?

4. What free play activities are typical in the classroom (dress-up, housekeeping, block building, etc.)?

5. What are the consequences for disruptive or inappropriate behavior in your classroom (temporary removal from the activity, loss of recess, etc.)?

SUPPORT SERVICES

1. Are support services provided to the child, staff members, or both?

2. What support services are available to the classroom? How often? Where are the services provided?

   a. resource teacher
   b. speech therapist
   c. physical therapist
   d. occupational therapist
   e. adaptive physical education
   f. paraprofessional aide
   g. community volunteers
   h. foster grandparents
   i. other _____

3. Do parents aid staff members in the classroom? Provide follow-up activities?

4. Do classmates or older students assist children with special needs?

Adapted from Susan A. Fowler's work on Integrating Preschool Handicapped Children Into the Regular Education Classroom, Bureau of Child Research, University of Kansas, Lawrence, Kansas 66045.

TEACHER TO TEACHER*

(Reflections from a receiving kindergarten teacher)

So, you may be having a student with special needs (KIT) in your room this year? I'm sure you are flooded with many thoughts and feelings. Some of them may be negative; panic, "I'm not qualified," "What shall I do?" As a kindergarten teacher of 16 years, I've had these same feelings. But, as I look back at the successes and failures, I know, "I can make this year a rewarding experience for myself as well as for my whole class!"

So far our project has addressed how to prepare children and parents for this transition from preschool handicapped classrooms to the regular classroom. Now it's time to prepare yourself!

You need to keep in mind that these "kids in transition" have individual personalities, the same feelings, and some of the abilities of your average kindergartner. However, they will have some different experiences for you to utilize!

Remember, you are here for all the children in your room, some days Johnny will take a bigger share of your time, tomorrow it might be Susy. Everything won't always be equal but keep in mind the total classroom--everyone benefits from kindness and patience.

Also, an open mind is essential--teaching and evaluation techniques may have to change. Not all your standard games and worksheets are going to work with a special needs child. It will be your challenge to adapt these games, worksheets, and possibly discussions to meet the needs of this child as well as the rest of your class. Instead of always using paper and pencil to write letters, try for example, covering the bottom of a cake pan with rice and then having each child write the new letter in the rice with his/her finger. This could be used as an evaluation for the child who is not able to use a pencil. As a bonus you may find other students benefiting from some of these unique learning and evaluation techniques. Look how much you, as a teacher, have improved!

Your routine will be greatly challenged! A special needs student may be leaving the room for special help. Now is the time for the rest of the class to work on tasks which are beyond his/her grasp. Flexibility is the key, other people's schedules change on short notice--yours can too--it's not the end of the world!

You will be the coordinator of this child's activities during this year. Be sure to communicate any pertinent information to speech, OT, PT, LD, or other special education staff. Keep them informed of any testing being done or any parental wishes that would be of value to them. You might find periodic meetings helpful. It's a good idea to keep your principal well informed. He can also be a wonderful source of support!

Speaking of support--seek it out. Visit with other teachers working with your student in transition. Chances are they can give you the warm fuzzy you need. These same teachers can be a good source of information and ideas--ask them!

Try something new, it if fails, don't worry, try something else, everyone makes mistakes. When you learn from them, you have again improved yourself.

I hope I have given you some insights of what to expect in the coming year. Remember, nothing worthwhile is easy. You are a special teacher with a room full of special kids and "KITS". Enjoy them!

*These thoughts were shared by Marian Lenz, Kindergarten Teacher, Garner-Hayfield Elementary School, Garner, Iowa 50438.

What Does a Special Education Student (Preschool Handicap) Need for Kindergarten?

(Rated as to highest priority beginning with number one.)

1. Following classroom routine and rules
   Working on own and working in group setting. Child also knows what day to go to music, art, P.E.

2. Displays appropriate classroom behavior
   Such as voice level, when one can leave seat, raising hand.

3. Group attending skills
   Also known as deadman skill. Child is able to find a place in the group and sit. This is child's responsibility.

4. Group participation
   Able to raise hand and turn-taking.

5. Direction following
   Can adapt to changes in routine, can follow directions on worksheets.

6. Independent task work
   Child completes work without adult supervision and reinforcement. Child doesn't go to teacher for help if can't do task. He/she tries to complete task another way, cheat, ask a friend--then can ask teacher.

7. Child takes care of own toileting skills and putting on of own clothes

8. Problem-solving!

9. Social play skills

10. Functional communication skills
    (expressive language)

From: Lisbeth Vincent, Ph.D.
432 N. Murray, Room 309
Department of Studies in
Behavioral Disabilities
University of Wisconsin
Madison, Wisconsin 53706
(608) 263-5824

STRATEGIES FOR TEACHING SURVIVAL SKILLS

The following instructional strategies are adapted from Out of the Nest,* a publication which was the result of a workshop about survival skills that are necessary to function in kindergarten. These skills are not requirements but the more independent a child becomes in these areas, the higher the degree of success.

The next page lists the survival skills area. The following strategies can be useful when implementing IEP goals and objectives.

It's interesting to note that the skills listed are functional rather than conceptual, perceptual or teaching oriented. True, these latter skills are important but they are not the only ones necessary for success. Possibly it is not so much what is taught but how the child perceives himself/herself that makes the difference.

* Adapted from Out of the Nest, Instructional Strategies to Prepare Young Exceptional Children for the Mainstream, Wisconsin Department of Public Instruction, Madison, Wisconsin.

SURVIVAL SKILL AREAS

A. UNDERSTANDING SELF AND OTHERS

B. COMMUNICATING

C. TASK-RELATED

D. SCHOOL AND CLASSROOM RULES AND ROUTINES

E. SELF-HELP

Understanding Self and Others

1. Responds Positively to Social Recognition and Reinforcement
2. Separates From Parents and Accepts School Personnel
3. Expresses Emotions and Feelings Appropriately
4. Defends Self
5. Understands Role as Part of a Group
6. Respects Others and Their property
7. Willingness to Try Something New (Take Risks)
8. Plays Cooperatively

1. Responds Positively to Social Recognition and Reinforcement

Share accomplishments with parents and ask them to set aside a place at home for the child's "good work".

If you're using constant individual reinforcement, start phasing out and look at the child when you give group praise so that the child understands he/she is included in that recognition.

Have an "I Can" place in the room. Children tell when they are proud that they can do something. The new skill is added to the board. Examples: I can tie my shoes! Eric. I can count to five! Sarah. Include the teacher in the accomplishments.

2. Separates From Parents and Accepts School Personnel

Plan school visitations for parent and child ahead of time. Include an orientation to your program.

Teacher visits to the home are also helpful in making the transition. Bring pictures from school room to share with child.

If supportive personnel are unable to coax child out of room to receive other services, try working within the room or have a "buddy" accompany him/her.

3. Expresses Emotions and Feelings Appropriately

Alternative ways to "release" angry or mad feelings may be offered to the child who is aggressive. A punching bag in the corner may offer an alternative.

Use of puppets or dolls may prove helpful, a child may be able to tell you how the doll "feels" before he can reveal how he/she "feels". Role playing activities may also help children "act" out their feelings.

Let the child know it's okay to feel mad, bad, sad, etc., but that we need to find ways to get over those bad feelings without hurting others, i.e., quiet place, secret for teacher, etc.

4. Defends Self

Don't jump into children's conflicts. Whenever possible try to give them time to work it out themselves.

Role play with puppets.

Help the children understand that words can be used to defend self rather than striking out. You can do this with "brainstorming" in a circle meeting. Children and teacher should feel free to discuss a particular problem and possible solutions to that problem. Any solutions are acceptable. The group may role play constructive solutions.

Have a "talking corner", (two chairs facing each other). If possible, let the children in conflict go there to work out their problems alone. The only rule is that they may not tough each other--they must use words. Do not intervene. Let them decide what to doe.

5. Understands Role as Part of a Group

Roll call techniques are especially helpful in bringing about an awareness of other children. Vary this by calling out names and expect children to respond by raising hands, moving to seat, or standing. Ask if anyone is missing; give children time to determine who is not there.

Circle games in which everyone joins hands and moves together can also be helpful.

Include words like "everyone", "all" when giving directions to group to emphasize the inclusion of the total class.

Group projects such as:

1. A seasonal mural: Each child contributes a drawing or picture
2. A Christmas wreath: made up of outlines of each child's hands.
3. Cooperative puzzle: Everyone has a few pieces and children take turns placing them in frame.
4. Group bulletin boards: Everyone contributes material on various subjects, for example: "Our Pets", "Our Families", "Our Nature Walk", etc.

6. Respects Others and Their Property

When teaching movement activities emphasize that everyone needs their own "space" to move within. Point out that when they allow for enough space between themselves and their neighbors they don't bump into each other. Generalize this concept to walking in line, playing on the playground, etc.

The child must respect his/her own property as well, so assign each child a special cubby-hole where he/she can place personal belongings. A child may only take objects out of another cubby-hole when he has the owner's permission.

7. Willingness to Try Something New or "Take A Risk"

Avoid saying "be careful"; it's better to be specific and say something such as "hold on tight", "put your foot up next".

If a child continually fails with a specific task or material, it may be better to remove the material for a time.

Reinforce the child when he/she attempts a more difficult task.

Sandwich new, challenging material between old, reinforcing material. Begin and end the lessons with something that the child knows and enjoys--put the "meat" of the lesson between this material.

8. Plays Cooperatively

Provide play materials that foster cooperative play. Teeter totters and wagons encourage "twosomes".

Pair children who play well with those who don't. (Avoid threesomes, "odd-man-out" for child having problems in this area.)

Provide game boards that children can work together in small groups without teacher's help. As the school year progresses increase play activities that require independence and cooperation.

COMMUNICATING

1. Communicates Own Needs and Wants
2. Answers Questions About Self and Family
3. Responds Appropriately When Comments Are Directed to Him/Her
4. Attends to Speaker in a Large Group
5. Initiates Interaction With Peers and Adults
6. Answers Questions About Stories, Films, Etc.
7. Relates Experiences and Ideas to Others
8. Asks Questions to Get Information

1. Communicates Own Needs and Wants

Anticipate child's wants and needs. Initially cue the child verbally, giving him/her necessary words. Fade cues to allow child to initiate as much on his own as possible. Perhaps other children could cue child.

Make sure adults are not meeting child's needs before child has to ask or tell. For example: Wait until child asks before giving snack or drink of water.

Have other children model asking for their needs to be met--praise them and verbalize what they have done in front of the other child. For example: "I like the way you raised your hand and said 'May I use the red paint' when you needed red."

Set up activities where children must ask others to get materials to complete their projects. For example, if the task is to paint a picture using three colors, give each child one jar of paint, each a different color. Or, if children want seconds on snacks, require them to ask.

2. Answers Questions About Self and Family

Teachers use a variety of materials to help children learn and verbalize pertinent information about themselves. Playing mailman is a fun way for children to learn their name and address. Small paper houses are used with the child's address on it. Children send a letter home to mom and dad when they have memorized their addresses. Children can also check each other out by asking "What is your name?"

Keep "abreast" of interesting events going on at home. A "traveling notebook" can give you new information to ask children about.

Toy telephones can be used to learn phone numbers. Place phone numbers on large cards or make a class phone book. have children pair off and call each other.

3. Responds Appropriately When Comments Are Directed to Him/Her

Remember that you are an important model--the children will imitate the way you greet others.

Practice greetings with children using "hello", or "good morning" everyday. Encourage them to respond to the greetings of others as well.

Puppets or dollhouse figures offer another avenue for children to converse.

4. Attends To Speaker In A Large Group

Be specific as to exactly what you want from the children. A key phrase might be "I know you're listening when I see your eyes", "Let me see your x-ray eyes."

Seat the child near a peer who is attending well. (Reinforce appropriate attending). If the child is constantly distracted, cue him/her to sit near you or in the front row. At a table activity, place him/her between two good peer models, rather than at the head or edge of the table.

Often children can take the role of the teacher so they are listening to each other as well. Children enjoy this role.

Ignore interrupting behaviors as much as possible and reinforce appropriate attending.

5. Initiates Interaction With Peers and Adults

Teachers may need to manipulate situations which prompt a child to approach a peer, i.e., telling the child to find a buddy to help him/her get milk.

Certain "rules of the roost" force children to approach the teacher, such as requesting materials or permission to use the bathroom, etc.

Set up the physical environment so that children are facing each other in coupled activities. Provide play materials that encourage interaction.

6. Answers Questions About Stories, Films, Etc.

Checking a child's level of comprehension of a story by asking questions is a common practice but there are a variety of ways to strengthen this skill such as:

Use flannel board figures for familiar stories. Let children manipulate figures while you tell story--or they can do the whole thing if possible. Let two children play with flannel board characters telling story to each other.

Ask various levels of questions so all children can answer on their own level. For example,, if you point out an animal from a story and ask, "What is this?" the child must only recognize or remember. Another question like, "Which animal in the story is white, has four paws and makes a good pet?" requires the child to put several pieces of information together to produce an answer.

7. Relates Experiences And Ideas To Others

Start individually or in small groups before expecting children to perform in large groups.

The teacher may request the children to share or relate an experience. For example, "Steve, tell us what you ate for breakfast?" or "Tell us about something you saw on your way to school.", etc.

A "Picture Place" can be created--a special spot for children to bring pictures that they want to share and tell about. (Cover with Plexiglas so pictures aren't smudged.)

8. Ask Questions to Get Information

Bringing new unusual objects into the classroom is an excellent way to stimulate a child's curiosity.

Bring a paper bag or a box to school. Place something from the classroom in it. Children must ask questions to find out what it is. "What color is it? Can I play with it? Can I eat it?" No guessing is allowed until everyone has asked a question.

Whenever new people or special visitors are in the classroom such as the nurse, policeman, parents, family, etc., allow a time for the children to ask them questions.

TASK-RELATED

1. Holds and/or Manipulates Materials
2. Follows a Three-Part Direction Related To Task
3. Makes Choices
4. Finds Materials Needed for Task
5. Works on Assigned Task for 15 Minutes
6. Completes Tasks of Ability Level Independently
7. Self-Corrects Errors
8. Recalls and Completes Task Demonstrated Previously

1. Hold and/or Manipulates Materials

To manipulate scissors, brushes, pencils, and crayons is sometimes difficult. Some readiness activities are suggested to increase fine motor skills, specifically to increase muscle strength in hand and to develop an adequate pincer grasp.

To build hand strength, provide activities such as squeezing tennis balls and nerf balls, manipulating potter's clay and clothespins. Kitchen and ice tongs can be used to pick up large and small objects. Tug of war games will also build hand muscle strength.

To enhance pincer grasp: plan activities using tiny beads, cereal, marbles, pennies, buttons, chips, popcorn, pins, pegs, paper fasteners, beads, blocks, puzzles, pegs, lace cards, snaps, zippers, buttons, toothpicks to be placed in styrofoam holders, paper clips to be placed on cardboard, small round loops can be put on tall, thin peg or dowel.

Suggestions for adapting writing materials: use three-corner pencil holder, built-up pencil (use clay), velcro-grip holder.

2. Follows 3-Part Direction Related to Task

Start with one or two step visual directive games (actions, use of body). The children can model a series of actions, such as touching body parts, moving to music, playing instruments.

Next pair visual directive with verbal directive. ("When I say one, clap your hands, when I say three, sit down.")

Child follows verbal directions without visual cues with manipulative materials. (Example: Place child behind screen. Place blocks in front of child. Child builds tower according to specific verbal directions. Compares end result to teacher model. Any manipulative items can be used.)

Write directions on .
Have child pick up one of each. Adult reads it for child.
Lower functioning children can just choose and .
(Two step).

Go to the door...	touch your nose...	and clap your hands.

Play auditory memory/listening games such as: "I went to the store and bought..." Each child repeats what others said plus adds one of their own. Use picture clues at first and withdraw them. Play restaurant with picture cards representing the menu displayed prominently--one person places an order and the waiter/waitress gets the order.

3. Make Choices

Use snack time, art time, surprise times as opportunities to make choices.

Encourage parents to let their children make choices at home regarding wardrobe, breakfast, etc.

Provide choices through learning centers or all lessons where opportunity arises.

Examples of choices might be choosing crayon, marker, colored paper, brush, paint shirt, and on to deciding which activity they would like to do next.

4. Finds Materials Needed for Tasks

Devise short games which require children to find certain supplies and materials in the classroom.

Keep materials in the same place and easily accessible to the children.

Have a discussion with children beforehand. What will we need for this task? Where can you find the supplies? Point out the places.

Accept the fact that children may use a trial and error approach when the selection is left up to them.

5. Works On Assigned Task for 15 Minutes

Start with a task which is appropriate for the child and one you know he/she will be successful with. Many short, highly motivating tasks may have to be used initially to hold attention and promote task completion. Teacher may wish to chart amount of time on task at first and build expectations for child from data collected. The use of a timer or hour glass will aid the child in determining how much time he/she has or when time is up. The child may also be grouped with a partner who has adequate on-task behavior and thus model the appropriate behavior. Build up time gradually according to child's age and ability level. Be consistent and carry through same expectations for attending throughout all classroom activities.

6. Completes Ability Level Tasks Independently

Points to consider when determining task level are: length of time needed to complete task, number of items,, cues needed, setting of task, and reinforcement appropriate to group or child. Begin with short simple tasks which you know the child can complete successfully.

Adults and peers can be use as reinforcers and models.

Increase length and complexity of task as children succeed.

Fade out visual and auditory cues on a gradual basis.

Reward them with personal "favorite" activities.

Special educators with smaller classes may find it hard to "resist" helping a child. Force yourself to let the child tackle a task on his/her own. You won't always be there to show him/her how.

7. Self-Correct Errors

Make sure children understand basic concepts required for specific activity. Example: same/different, etc.

The teacher can provide a model representing the correct answers, allowing children to match own work to teacher's model or peer's model.

Teach and reinforce idea that "everyone makes errors"--what is important is what you do when error is made--what strategies can you use to cope with errors.

Allow time in your "error-free" learning situation for errors to be made and coping strategies modeled. In other words, plan some intentional errors so the child can learn under a trial-and-error approach.

8. Recalls and Completes Task Demonstrated Previously

Have the children perform action songs, sing short fun songs, or recite poems and nursery rhymes.

Read stories and have them answer simple questions.

Plan several games and lessons with multiple directives.

Provide reminders and appropriate peer models, initially to build in desired response.

SCHOOL AND CLASSROOM RULES AND ROUTINES

1. Can "Line-Up" and Stay in Line
2. Raises Hand and/or Gets Teacher's Attention When Necessary
3. Replaces Materials and "Cleans-Up" Workspace
4. Moves Through Routine Transitions Smoothly
5. Waits to Take Turns and Shares
6. Controls Voice in Classroom
7. Stays in "Own Space" for Activity
8. Knows Way Around School and Playground

1. Can "Line-UP" and Stay in Line

Play "Follow the Leader" games.

To facilitate the understanding of a "line", have children position dolls, figures to other objects in line.

Observe older children in line and model "the big kids".

Line up chairs to play bus.

Practice lining up and taking walks in "pairs" also.

2. Raises Hand and/or Gets Teacher's Attention When Necessary

Determine when children need to raise hands to speak, i.e., circle time not learning center time and be consistent so children learn to discriminate.

Raising hands may be illustrated using a puppet or stuffed animal raising his paw up.

Ignore "blurted out" responses when they are at inappropriate times and praise children who remember to raise their hands. Be sure to recognize the ignored child as soon as he/she remembers to raise his/her hand to speak.

3. Replace Materials and "Cleans-Up" Workspace (or Playspace)

Establish a routine and have a specific place for all things to be returned. Pictures or color coded outlines and labels can be used a cues.

Have clean-up time be a separate time; "It's time to clean up!" Give children an auditory cue which means clean up, such as chords on the piano.

Use reinforcers such as stickers or happy notes for clean-up.

Plan activities after play time which will motivate children to clean up and join the next activities.

4. Moves Through Routine Transitions Smoothly

Sequencing the events of the day is not only reassuring but gives the children a sense of what happens first, next, etc.

Challenge them to recall the "plan for the day"; Ask questions like, "We are finished with this activity, what will we do next?"

Arrange for orderly transition with a game, i.e., everyone with brown hair may start a new center, wearing the color red, etc.

Awareness of daily schedule gives children a sense of security--major changes in schedule should be shared with the children in advance, whenever possible.

5. Waits to Take Turn Shares

Cooking activities are easy to organize turns for by using the adding of ingredients and the actual mixing as "turns"!

The children's names on the "Helper Charts" are alternated so that all the children get to have a "turn" at the different jobs.

Structure activities so children have opportunities to share with each other, i.e., in art two children may be required to share crayons.

6. Controls Voice in Classroom

Distinguish between loud and soft voices. Discuss why we use different voices at different times in different places. Review the specific places where you can use loud and soft voices.

Play listening games: to hear others in the building, to hear nature sounds, etc. Make children aware of the special sounds we cannot hear when loud noises surround us.

Discuss indoor/outdoor voice rules.

7. Stays in "Own Space" for Activity

Pretend there is a "bubble" around you; allow enough space for your neighbor.

Separate carpet squares or small rugs are helpful for children to "contain" their own space.

Use name cards to label spots where children are to sit.

8. Knows Way Around School and Playground

Orient children to different rooms in the school. Plan a "school" unit at the beginning of the year, emphasizing vocabulary (such as office, gym, kitchen, etc.) and tour

where these places are as a large group, small group, or individual. Make a small scale map of school on tagboard.

Teacher and staff should list types of errands which would take the child out of the room. Examples: a) Attendance slip to office, b) lunch count to office, c) get milk for snacks, d) take books to library, e) take note to another teacher or to an office, f) get materials, g) get refrigerated supplies for cooking/snacks. Teacher can decide which are easy or difficult and start with the easier task.

SELF-HELP

1. Will Put On/Off Outer Clothing Within a Reasonable Amount of Time
2. Cares for Own Bathroom Needs
3. Feeds Self
4. Gets On and Off of Bus
5. Aware of Obvious Dangers and Avoids Them

1. Will Put On/Off Outer Clothing Within a Reasonable Amount of Time

Allow plenty of opportunities for dressing, especially at the beginning of the "cold weather" season. (Remember it's part of the curriculum).

At dress up corner time, use plenty of clothes with a variety of fastening so the children get plenty of practice.

Emphasize to all adults who work with the child (including parents) to allow plenty of opportunities for dressing. Though it takes longer to let the child dress him/herself, independence is the goal.

If necessary, use clothes with adaptive closures to help the child be more independent. Zippers and velcro closures instead of buttons.

2. Cares for Own Bathroom Needs

This should certainly be a "high priority" skill but "caring for own bathroom needs" may mean that the child change his/her own diaper (i.e., Child may be capable of changing diaper but not physically able to "feel" the need to use the toilet). The child should help to the greatest extent that he/she can.

3. Feeds Self

This skill is also "assumed" to be within the child's capabilities by the time he/she reaches kindergarten. However, the physically handicapped child may still have difficulty in this area. Since this is a basic life skill, the child's early teachers and therapists will have spent much time in this area but if physical assistance from an adult is still needed when the child enters kindergarten an aide should be available to assist the child at snack time.

4. Gets Off and On Bus

Use a buddy system with older students.

Set up bus in classroom and practice moving up and down the aisle, in and out of seats, etc.

Ask bus driver to visit classroom and explain rules of the bus.

Encourage the adults to let the children step down from the bus independently when possible.

5. Aware of Obvious Dangers and Avoids Them

Discuss and practice safety rules (cooking, playground, etc.) and encourage parents to do the same at home.

To initiate discussion, use open sentences--"What would happen if . . ."

Utilize community resource people such as firepersons and policepersons.

Ask a volunteer to portray "Samantha Safety", who shares safety rules with children.

Adapted from Out of the Nest, Instructional Strategies to Prepare Young Exceptional Children for the Mainstream, Wisconsin Department of Public Instruction, Madison, Wisconsin

PREPARING REGULAR CLASSROOM PEERS

It is important for the preschool handicapped child to be accepted by his peers. In order for this to happen, the children need to understand the child's disability. There are many activities that a class can do both in and outside the classroom to enhance this understanding.

Among these are:

1. "Kids on the Block"--a puppet show usually available through area education agencies which demonstrates various disabilities.

2. Invite early childhood special education teacher and the child's parents to talk with the class regarding the disability.

3. Use stories--consult with the school librarian. Several stories are written on a child's level about various disabilities. (See appendix.)

4. Demonstrate your own assurance about the new child. There is nothing to be fearful of--we are afraid of what we know the least about--become informed.

5. Invite an adult who has a disability to share information with the class.

6. Have the kindergarten students visit the early childhood special education classroom, nursing homes, or other settings where disabled individuals might reside.

7. Show movies and filmstrips which depict handicapping conditions. (See appendix.)

8. Experience a visual impairment--blindfold the children and ask them to find something in the room. Contact your local teacher of the visually impaired for additional suggestions.

9. Experience a hearing impairment--show a movie without the sound--then ask questions.

10. Have the teacher for the hearing impaired demonstrate sign language. Teach the children several signs.

11. Experience a physical disability--have the children take turns maneuvering a wheelchair around desks, through doors, or to get a drink.

12. Ask the children to tell about other handicapped children they know personally.

"Reports, Reports, Reports... Now What?"

The staffing is completed, the child is in your program and you have just received the child's folder. Now what? The following are a few suggestions for deciphering the reports contained in the folder.

1. Don't panic. Think of the child first.

2. Concentrate on the most recent reports. Don't worry about the Iowa City report from five years ago. However, those reports can give you relevant background information.

3. Locate the sending teacher's report. It should give you information about the child's strengths and weaknesses in the classroom. It will also give you a perspective of what you can expect from the child in the classroom.

4. Locate the support staff's (i.e., psychologist, school social worker, etc.) reports which will give you additional information regarding child's disability and needs.

5. Review and become familiar with the child's most recent IEP. Remember, the other team members also share the responsibility of implementing the IEP goals and objectives.

6. If there are questions regarding any of the reports, contact the appropriate support staff.

7. Refer to the appendix for descriptions of disabilities and definitions of terminology.

8. Ask questions!! It's okay! No one expects you to understand all the jargon used by various disciplines.

Teachers Communicating With Parents

Communication with the child's parents becomes increasingly important as preschoolers begin their transition. This time involves new teachers, classroom environments, schedules, peers, and possibly a different school building and transportation. Naturally, these changes create many new concerns for both the child and parents.

Maintaining regular contact with parents is essential to addressing their concerns, meeting the child's needs and preventing any unnecessary misunderstanding. Frequent communication with parents will facilitate an effective, trusting partnership between home and school and enable a handicapped child to receive maximum benefits from his/her educational experience.

Guidelines to developing effective communication with parents:

1. Upon learning that a handicapped child will be entering your classroom, initiate a contact with the child's parents by phone or letter. Introduce yourself and express your interest in learning more about the child. Offer to make a visit to the child's home or invite the parents and child to your classroom for a visit.

2. Discuss with parents their needs for feedback or reports on how their child is doing at school. Establish <u>how</u> the information will be communicated, i.e., phone calls, weekly notes, meeting with the parent at school, or daily report card, etc. Determine the <u>frequency</u> of the communication, i.e., daily, weekly, monthly, scheduled Parent-Teacher Conferences, etc. Remember this communication does not have to involve a lengthy amount of time. For example, use a daily report card that has been designed for quick use at the end of the school day.

3. Know the family's limits when giving suggestions for work that can be done at home with a child. Everyone has a personal limit on how much he or she can do for a child at home or in the classroom. Keep in mind the family's work schedule, availability of both parents, size of family, etc. This will assist in developing reasonable expectations for work to be completed at home with a child.

4. Focus on the child's education and development during contacts with the parents. For example, create a list of accomplishments and areas needing improvement that you have observed in the child. This will aid in focusing the discussion on the child's educational program.

5. Be reassuring but honest in your communication of information. Parents may be worried and upset when their child is to be evaluated or re-evaluated. It might be tempting for a teacher to tell them not to worry, that everything will be fine, which would be natural as we want to soothe a parent's anxiety. However, a false sense of confidence can be hurtful. Be supportive, calm, understanding, but be truthful. Remember, it is okay to say that you don't know the answer when parents ask questions. Direct parents to the resources that can help.

6. Recognize and deal with your feelings about handicapped children and their families. Feelings such as blame, anger, sorrow, nervousness, and fear are understandable. However, getting to know the child and his/her family helps reduce some of these feelings.

7. Think positively about children with special needs. Remember your thoughts and feelings abut handicaps are reflected to parents through communication and your working with their child. It is most helpful if both teachers and parents can see a handicapped child as a <u>child first</u>, someone who can grow, learn and improve.

PROGRESS LETTER FROM _____

This week I have been working on _____

_____

_____

_____

I need to improve some in _____

_____

_____

I did very well this week on _____

_____

_____

Some things we might work on at home are _____

_____

_____

_____

_____

47

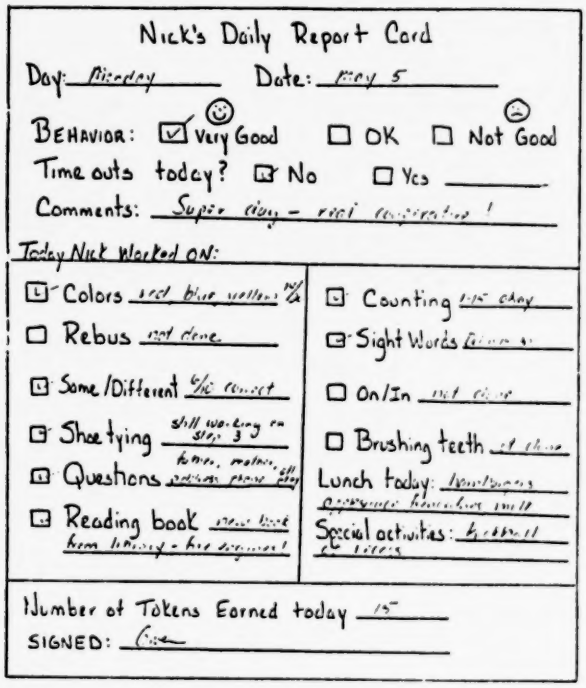
Name: _____

DAILY REPORT

Opening	Language	Art/Music/P.E.
Speech	Recess/Lunch	Group
Group	Individual	Recess/Bathroom

Uses:
- for immediate reinforcement after each period.
- For students who are non-verbal, younger, or those who can't read to share with parents who may have the same disabilities.
- Modify to fit individual needs and subjects.
- Fill in the "smiley" face to indicate how the student did each period.

Improving Home-School Communication:
Sharing Daily Reports



Nick's Daily Report Card

Day: Monday Date: May 5

Behavior: ☑ Very Good ☐ OK ☐ Not Good

Time outs today? ☒ No ☐ Yes _____

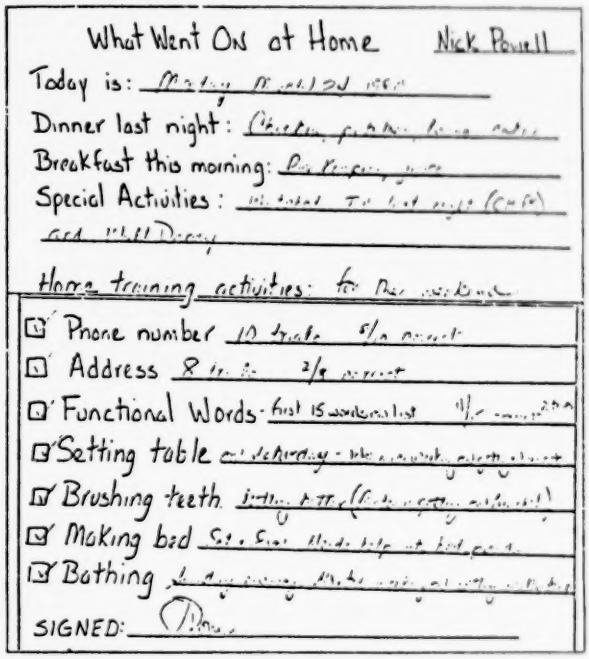
Comments: Super day - real cooperative!

Today Nick Worked ON:

- ☑ Colors red, blue, yellow 4/4
- ☐ Rebus not done
- ☑ Same/Different 6/6 correct
- ☑ Shoe tying still working on step 3
- ☑ Questions
- ☑ Reading book
- ☑ Counting
- ☑ Sight Words
- ☐ On/In
- ☐ Brushing teeth
- Lunch today:
- Special activities:

Number of Tokens Earned today 15

SIGNED:



What Went On at Home Nick Powell

Today is:

Dinner last night:

Breakfast this morning:

Special Activities:

Home training activities:

- ☑ Phone number
- ☑ Address
- ☑ Functional Words
- ☑ Setting table
- ☑ Brushing teeth
- ☑ Making bed
- ☑ Bathing

SIGNED:

By T. Hennessy Powell

The fact that parents can have a direct, significant, positive impact on the education of their disabled child has been well documented during the past few years. Yet, to have that impact parents need to be actively involved in their child's education.

Public Law 94-142, which is federal legislation outlining a framework for providing education to handicapped children, mandates that parents be involved as critical team members in providing educational services. This involvement must go beyond mere attendance at Individual Education Plan (IEP) meetings and providing the numerous signatures required for special education services; such involvement is only superficial. Active involvement calls for something more.

Actively-involved parents have the responsibility of monitoring their child's progress toward the stated goals and objectives of the IEP. Such monitoring is a difficult task at best. As a parent of a disabled child, I found it quite difficult to know how my child was doing on a daily basis in regard to the IEP objectives. Typically, I only received reports at the end of the school year. If my input was sought at all, it was on an irregular basis and was a direct response to a problem my son was having. My wife and I realized that we had become problem solvers and were only contacted during a

0046-9157/80/1005-0036$01.00/0
Copyright © 1980 Psy Ed Corporation
BEST COPY AVAILABLE

crisis when our son misbehaved. We did not have a good day-to-day picture of his classroom behavior. Receiving information only in emergencies is not fair to the child or the parents, nor does it allow parents to be actively involved in their child's total education. We realized that there was a need for a communication system between school and home that would allow for greater parental involvement and would help object monitoring of a child's program.

Daily communication is warranted for yet another reason. Many children, especially those with speech and language problems, do not openly share their daily school activities with their parents. Most likely, these children do not discuss home activities with their teachers either. A language training program should be based on a child's daily events. It is difficult to provide relevant language training unless there is daily communication between home and school. Also, knowing what has happened at school helps to understand the child's behavior at home, and vice-versa.

To coordinate training efforts, monitor educational progress and establish a base for language training, my wife and I decided that we needed a formal communication system between home and the school. After discussing these needs with the school staff, daily phone calls were initiated. After three days, we all decided that this system was unmanageable. The orchestration needed to arrange these calls was too much to handle because everyone involved had busy schedules.

The school staff then suggested we try sending a notebook back and forth. The notebook was to contain daily handwritten notes. However, this was not a workable system either. The notes required too much time and lacked a structure to provide concise information. Strike two! We needed a simpler, more direct way to communicate with each other.

As a parent of a disabled child, I found it quite difficult to know how my child was doing on a daily basis in regard to the IEP objectives.

Daily Report Cards

The next attempt at establishing an effective communication system proved to be quite successful. I was familiar with the work of several educators who used a procedure by which parents rewarded their child at home for good behavior at school. This procedure called for a daily note sent home by the child's teachers. Although the intent of these daily reports was a bit different from the needs my wife and I had, these procedures provided the groundwork for the solution to our problems. A daily report card appeared to provide an efficient method of communication that, if structured properly, could also provide coordination and monitoring of training.

The first step in implementing this system was to discuss it with the school staff. Their positive response encouraged its development. We knew from the start that the card had to be designed so it could be easily used. It could not be very complicated nor could it cause the sender or receiver to spend much time with it. The design of the card also needed to incorporate features that would make it possible to teach our son how to read it, even if only in a general fashion. Another crucial feature was that the card had to be easily sent from school to home and back again.

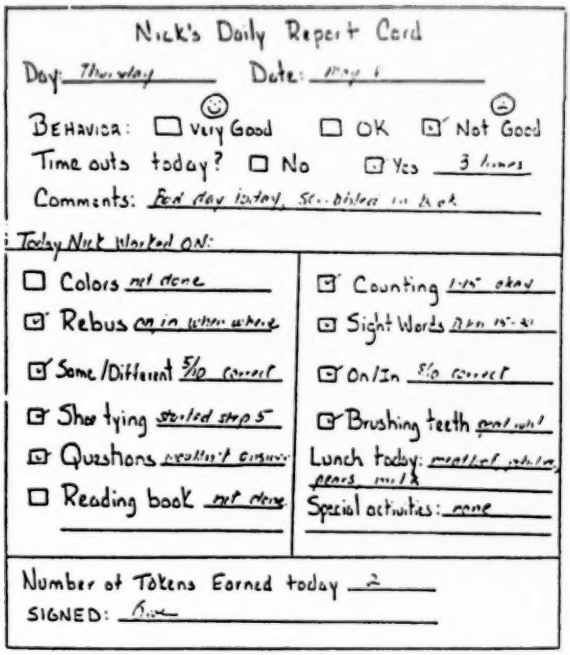
Since this idea originated from parents, my wife and I felt it was our responsibility to design the card and provide the necessary copies to the school. We wanted to make this system as easy as possible for our son's teachers to implement.

Our son's IEP provided the basis for the card's design. The training areas listed on the IEP became the content of the daily report card. A few key words from each learning objective were used to dscribe each area. The teacher marked that area if the training took place that day and filled in a brief note about the results of that training. Since we were very familiar with the IEP, the teacher's marks were typically abbreviated notations about the data recorded on the learning objective taught.

Also included on this daily report card were sections that referred to our son's behavior at school and the behavior management program established earlier. A general statement about his behavior was included, as well as information about whether he was "timed-out" and how many token reinforcers he earned. This was important information as we wished to reward our son at home for having a good day at school. Space for teachers' comments regarding special activities and the lunch menu were included on the card. Ample room was left for notes and other information as needed (see samples).

The results of using this card were quite favorable. We received daily information about our son's activities and were therefore able to coordinate our training efforts and monitor his progress toward the IEP objectives. I discussed his system with the school staff several times. We have all agreed that it takes very little time and that it

BEST COPY AVAILABLE



Nick's Daily Report Card

Day: Thursday Date: May 6

BEHAVIOR: ☐ Very Good ☐ OK ☑ Not Good

Time outs today? ☐ No ☑ Yes 3 times

Comments: Bad day today. Stubborn in PM

Today Nick Worked ON:

☐ Colors not done	☑ Counting 1-15 okay
☑ Rebus on in when where	☑ Sight Words Non-ex
☑ Same/Different 5/6 correct	☑ On/In 5/6 correct
☑ Shoe tying started step 5	☑ Brushing teeth good job!
☑ Questions verbal comm.	Lunch today: mostly whole pears milk
☐ Reading book not done	Special activities: none

Number of Tokens Earned today 2

SIGNED: Mom

Conclusion

Establishing a communication method that allows parents and teachers to coordinate efforts, monitor progress and establish a base for language training is by no means an easy task. It takes commitment from all parties to make such a system work. The system presented here is based on the premise that providing a disabled child with a proper education is a team process, with each member carrying out a vital role. Without an efficient, effective communication system the team process cannot function. The daily report card system is one way to help establish and maintain proper communication among team members.

During the past three years, I have shared this system with many parents and teachers. From the reports I have received, the method is easily used and has helped open doors to effective communication. It has also proved helpful at times when tension between home and school has been building. Providing the various people who are involved with an easy system that relays necessary information is the first step in helping persons work together in a cooperative fashion.

The daily report card system has been successful for a number of people committed to the team process. Those responsible for coordinating training and monitoring prgress may find this system worth the time and effort necessary to implement it. Being actively invoved with a child's education has so many advantages that the requisite cost, time and effort are minor when compared with the advantages. ◘

The system presented here is based on the premise that providing a disabled child with a proper education is a team process, with each member carrying out a vital role.

provides a structure or efficient and effective communication. A testimonial to these good results is the fact that the staff initiated the system with several other families involved in the program.

A Two-Way Street

At first the daily report cards came from school to home. Effective communication, however, is a two-way street. If parents need to know what is going on at school, then teachers also need to know what has occurred at home. This is especially true if the parents are conducting a home-based training program. A further expansion of this system called for a card that went from home to school. We used a similar design for the home-to-school card.

T. Hennessy Powell is currently pursuing a doctoral degree in special education at George Peabody College for Teachers of Vanderbilt University. He has worked as a teacher of the disabled with several private and public agencies. Mr. Powell is also the parent of a developmentally disabled child.

*Reprinted with permission from THE EXCEPTIONAL PARENT, 605 Commonwealth Avenue, Third Floor, Boston, MA 02215 (617) 536-8961

PARENT OBSERVATION SHEET FOR PROGRAM VISITATION

I. Staff

1. What is the ratio of adults to students? (How many teachers and aides work with how many students?)

2. Are the teachers and aides warm in their behavior with the children? (Do you see hugs, touches, smiles, or other behaviors that you feel demonstrate warmth and caring?)

3. Is the teacher open to communication? Does he or she welcome parents to visit and talk?

II. Physical Environment

1. Is the classroom big enough for the number of children present?

2. Can the classroom and facilities be adapted to meet the physical needs of your child? (For instance, if your child is in a wheelchair, are the classroom and materials accessible?)

3. Is the classroom bright and cheerful? Does it look like a place children want to be?

4. If your child has a special learning need, can part of the classroom be adapted to that need? (For instance, if your child is highly distractible, can a corner of the room be made a "quiet place" with less stimulation?)

III. Teaching Techniques

1. How much time do students spend working individually with teachers and aides? How much time is spent working in groups?

2. How much time do students spend "waiting" while teachers and aides work with other children? How does the teacher handle this time? If appropriate to their developmental levels, are children encourage to work independently with materials.

3. Does the teacher have a lesson plan for each day? Will she or he explain the plan to you?

IV. Classroom Organization/Discipline

1. Do the children seem aware of classroom rules? Can the teacher explain the classroom rules to you?

2. How consistently are rules enforced?

3. What kinds of behavior seem to get the most attention from the teachers and other staff (i.e., talking out loud, pushing, hitting, bothering child seated nearby, etc.?)

4. What techniques do teachers and aides use to discipline children?

5. What happens when a child misbehaves? Who handles the problem?

6. How do teachers and aides handle disagreements between children?

V. The Teacher

1. Has the teacher worked with other special education students?

2. Did the teacher ask questions about your child's handicap?

3. Has the teacher worked with AEA support staff, in his/her building, who may work with your child?

NOTES:

Adapted from Project Transition Parent Notebook, Mental Health Mental Retardation Authority of Harris County, Houston, Texas

DEFINITIONS OF HANDICAPPING CONDITIONS

Listed below are the handicapping conditions as defined in the Iowa Rules of Special Education (1985):

1. "Behaviorally disordered" is the inclusive term for patterns of situationally inappropriate behavior which deviate substantially from behavior appropriate to one's age and significantly interfere with the learning process, interpersonal relationships or personal adjustment of the pupil to such an extent as to constitute a behavioral disorder.

   a. Clusters of behavior characteristics of pupils who are behaviorally disordered include: Cluster I--Significantly deviant disruptive, aggressive or impulsive behaviors; Cluster II--Significantly deviant withdrawn or anxious behaviors; Cluster III--Significantly deviant thought processes manifested with unusual communication or behavioral patterns or both' and, Cluster IV--Significantly deviant behavior patterns characterized by deficits in cognition, communication, sensory processing or social participation or a combination thereof that may be referred to as autistic behavior. A pupil's behavior pattern may fall into more than one of the above clusters.

   b. The determination of significantly deviant behavior is the conclusion that the pupil's characteristic behavior is sufficiently distinct from that of the pupil's peer group to qualify the pupil as requiring special education programs or services on the basis of a behavioral disorder. The behavior of concern shall be observed in the school setting for school-aged pupils and in the home or center-based setting for preschool-aged pupils. It must be determined that the behavioral disorder is not maintained by primary intellectual, sensory, cultural or health factors.

   c. In addition to those data required within the comprehensive educational evaluation for each pupil requiring special education, the following areas of data shall be gathered when identifying a pupil as behaviorally disordered which describe the qualitative nature, frequency, intensity, and duration of the behavior of concern. If it is determined that any of the areas of data collection are not relevant in assessing the behaviors of concern, documentation must be provided explaining the rationale for such a decision. Such documentation will be maintained by the director.

"Setting analysis data" is information gathered through informal observations, anecdotal record review and interviews describing the setting from which a pupil was referred; documented prior attempts to modify the pupil's educational program so as to make behavioral and academic achievement possible in the current placement; and, social functioning data that includes information, gathered from sources such as teacher interviews and sociometric measures, regarding the referred pupil's interaction with his or her peers.

"Pupil behavioral data" are measures of actual behavior that include the specific recording, through systematic informal observations, of a pupil's behavior, including the frequency of behaviors of concern; and, measures of reported behavior that include checklists of rating scales and interviews that document the perceptions of school personnel regarding the behavioral pattern of the referred pupil and the perception of the pupil's home and school behavior obtained from the parent or surrogate parent.

"Individual trait data" is information about the unique personal attributes of the pupil. This information, gathered through pupil and teacher interviews and relevant personality assessments, describes any distinctive patterns of behavior which characterize the pupil's personal feelings, attitudes, moods, perceptions, thought processes and significant personality traits.

2. "Communication disability" is the inclusive term denoting speech and language impairments and hearing impairments.

3. "Deaf-blind" pupils have auditory and visual handicaps, the combination of which causes such severe communication and other developmental and educational problems that the pupils cannot properly be accommodated in special education program solely for the hearing impaired or visually impaired, without appropriate modifications.

4. "Hearing impairment", a communication disability, is a loss of auditory sensitivity ranging from mild to profound which may affect one's ability to communicate with others.

   a. "Deaf" pupils include those individuals whose hearing impairment is so severe that they do not learn primarily by the auditory channel even with amplification, and who need extensive specialized instruction in order to develop language, communicative and learning skills.

   b. "Hard of hearing" pupils include those individuals whose level of communication ability is adequate to allow them to acquire speech and language and to learn by auditory means although they may experience difficulty, under certain circumstances, in oral communication, language and learning skills with or without amplification, and who may need various classroom and instructional modifications in order to make full use of school experiences.

5. "Learning disability" is the inclusive term denoting the inability to learn efficiently, in keeping with one's potential, when presented with the instructional approaches of the general education curriculum. The inability to learn efficiently is manifested as a disability in an individual's reception, organization, or expression of information relevant to school function. This disability is demonstrated as a severe discrepancy between an individual's general intellectual functioning and achievement in one or more of the following areas: school readiness skills, basic reading skills, reading comprehension, mathematical calculation, mathematical reasoning, written expression and listening comprehension. A learning disability is not primarily the result of sensory or physical impairments, mental disabilities, behavioral disorders, cultural or language difference, environmental disadvantage, or a history of an inconsistent educational program. The following criteria shall be applied in identifying a pupil as learning disabled and in need of special education.

   a. Hearing sensitivity must be within normal limits unless the hearing loss is temporary or not educationally relevant, such as a high frequency loss above the speech range.

   b. Vision must be within normal limits after correction unless the impairment is temporary or not educationally relevant.

   c. Intellectual functioning must be at or above one standard deviation below the mean as measured by an instrument recognized as a valid measure of intellectual functioning. A total or full-scale score shall be used in applying the intellectual criterion. In cases where measured intellectual functioning does not meet this criterion, the individual responsible for assessing intellectual functioning shall state in writing the specific data which support that conclusion.

   d. A severe discrepancy between current achievement and intellectual functioning exists when a pupil has been provided with learning experiences that are appropriate for the pupil's age and ability levels, and obtained scores in the achievement area(s) of concern are below the pupil's present grade placement and are more than one standard deviation below the mean on the distribution of achievement scores predicted from obtained intellectual functioning scores.

In establishing the difference of one standard deviation, the effects of regression toward the man and errors of measurement must be applied. If the technical data necessary to account for the effects of regression are not available, the discrepancy between the obtained achievement and intellectual functioning standard scores must be at least two standard errors of measurement for the difference.

If norm-referenced tests are not available in a particular achievement area, the diagnostic-educational team shall state in writing the assessment procedures used, the assessment results, the criteria applied to judge the importance of any difference between expected and current achievement, and whether a severe discrepancy is present that is not correctable without the provision of special education.

In cases where a pupil's obtained scores on norm-referenced tests are not severely discrepant from intellectual functioning, but the results are suspect and the diagnostic-educational team believes that the pupil's current achievement is severely discrepant, the team shall state in writing the specific non norm-referenced data, including a description of the assessment procedures used and the criteria applied to determine the presence of a severe discrepancy, which supports the team's conclusion. In such cases, a copy of the supportive documentation will be maintained by the director.

e. A member of the diagnostic-educational team must observe the pupil's performance in the general education classroom setting for the school-aged pupils or in the home or center-based setting for preschool pupils. The primary purposes of the classroom observation are to seek evidence for the existence of a learning disability and to determine the degree to which the disability, if any, affects learning. The individual responsible for the observation must be someone other than the pupil's classroom teacher who is trained to use observation as a diagnostic procedure.

f. The severe discrepancy between achievement and intellectual functioning must not be primarily attributable to behavioral disorders, chronic health problems, physical impairments, environmental disadvantage, cultural or language difference or a history of an inconsistent educational program.

g. The degree of the achievement-intellectual functioning discrepancy may decrease as a pupil receives special education, progresses academically and maintains that progress. Consideration of these factors will be used

to determine a pupil's movement along the continuum of special and general education options, and in targeting appropriate transfer from a special education instructional program. A pupil who attains an achievement level commensurate with expected performance, given current grade level placement and intellectual functioning, and is able to maintain satisfactory educational performance in the general classroom setting shall be transferred from the special education instructional program.

6. "Mental disability" is the inclusive term denoting significant deficits in adaptive behavior and subaverage general intellectual functioning. For educational purposes, "adaptive behavior" refers to the individual's effectiveness in meeting the demands of one's environment and the "subaverage intellectual functioning" as evidenced by performance greater than one standard deviation below the mean on a reliable individual test of general intelligence valid for the individual pupil.

7. "Physical disability" is the inclusive term used in denoting physical or visual impairments of pupils requiring special education.

8. "Physical impairment", a physical disability, is manifested as an aberration of an essential body structure, system of function. Physical impairments are defined operationally in terms of orthopedic, neuromuscular, other health impairments, or any combination, which may be a result of congenital or acquired conditions of unknown or miscellaneous causes. These pupils may manifest functional impairments in body balance, ambulation and limb and hand utilization. the severity of these noncognitive functional limitations are such that the pupil needs special education.

9. "Preschool handicapped" are those pupils below the age of seven who require special education and who are not appropriately provided for within the scope of general education or other special education programs.

10. "Primary disability" is that disability with the most dominant characteristics and for which the greatest intervention is programmed. For those pupils with more than one disability, primary disability is a determination made by the director utilizing recommendations of the diagnostic-educational team.

11. "Profound multiple handicapped" are descriptive of pupils who may exhibit a combination of the following characteristics:

    a. Use no means of communication beyond affect responses or use an augmented communication system that is not standard symbol system to indicate needs and wants.

b. Are dependent in mobility or required supervision in order to meaningfully traverse between points in the environment.

c. Are dependent in all daily living activities.

d. Have minimal social interaction skills and may exhibit severe maladaptive behaviors.

e. Have mental, physical or sensory handicaps.

f. Have fragile medical conditions, including seizures.

12. "Severely handicapped" are pupils with any severe disability including pupils who are profoundly multiply handicapped.

13. "Speech and language impairment", a communication disability includes:

a. Impairment in language: A disability in verbal language resulting in a markedly impaired ability to acquire, use or comprehend spoken, read or written language due to difficulties in acquisition and usage of syntax, morphology, phonology and semantics.

b. Impairment in voice: An abnormality in pitch, loudness, or quality resulting from pathological conditions, psychogenic factors or inappropriate use of the vocal mechanism which interferes with communication or results in maladjustment.

c. Impairment in fluency: A disruption in the normal flow of verbal expression which occurs frequently, or is markedly noticeable and not readily controllable by the pupil. The disruption occurs to the degree that the pupil or pupil's listeners evidence reactions to the manner of the pupil's communication so that communication is impeded.

d. Impairment in articulation: Defective production of phonemes which interferes with ready intelligibility of speech.

14. "Visual impairment", a physical disability, is characteristic of pupils whose vision deviates from the normal to such an extent that they require special education. Educational functioning and visual and adaptive skills are used in determining needs of pupils with visual impairments.

ORTHOPEDIC HANDICAPS:

Abduction--The act of turning outward; the movement of part from the axis (midline) of the body.

Adduction--A movement toward a median line or axis (midline) of the body.

Ambulatory--Walking; able to walk.

Asymmetrical--Lack of symmetry, i.e., lack of similarity between corresponding parts or organs on opposite sides of the body that are normally alike.

Asymmetrical Tonic Neck Reflex--When a person is lying down and head is turned to one side, the arm (and perhaps the leg) extend on the face side and contract (flex) on the skull side; normal until around six months of age.

Bilateral--Pertaining to or affecting both sides of the body.

Body Alignment--The proper positioning of the body parts so that undue strain is not put on any one part, and deformities are prevented.

Bolster--Pillow or rolled towel that can be used to support various body parts in various positions.

Brain Stem--The structure at the base of the brain connecting the upper end of the spinal cord with the cerebral hemispheres.

Central Nervous System (CNS)--The brain and spinal cord.

Cephalo--Pertaining to the head.

Cephalocaudal Direction--In the direction of the long axis of the body, i.e., from head to tail.

Cerebellum--The center for the brain controlling balance.

Cerebellum--The small area of the brain at the base of the skull in the back of the head. It coordinates muscle movement, and is involved with balance.

Cerebrum--The highest center of the brain, controlling movement and speech.

Chromosomes--The parts of the cell that direct tissue development. The genes are carried on the chromosomes.

Clonus--Involuntary, rapid contractions and relaxations of a muscle.

Congenital--Present at birth.

Congenital--Refers to a disease or condition that is present at birth, and that is not necessarily caused by inheritance.

Constipation--Difficult, incomplete, or infrequent bowel movements.

Contraction--Shortening of a muscle to cause movement.

Coordination--Acting together in a smooth way; several muscle groups working together in harmony.

Cranial Nerves--Twelve nerves that connect the brain with the muscles and sense organs of the face, neck, eyes, ears, nose and mouth.

Crawl--To propel oneself on the floor while on hands and knees.

Creep--To propel oneself on the floor while on hands and knees.

Cyanosis--A condition in which a lack of oxygen in the blood causes the blood to be darker and the skin to look bluish.

Decongestant--a medicine used to dry up excess mucous caused by an upper respiratory infection.

Degenerative Neurological Disease--A condition that progressively destroys parts of the nervous system. This means that the symptoms of the condition become worse as time passes.

Diabetic Coma--A situation in which a diabetic does not have sufficient insulin and becomes drowsy, then unconscious.

Dialysis--A procedure in which a machine is used to clear wastes from the blood. Dialysis is necessary when the kidneys are not functioning properly.

Diarrhea--Excessive bowel movements of loose, watery stool.

Distal--Farthest from one point of reference.

Eczema--A dry, scaling condition of the skin, usually the result of allergy.

Edema--Swelling of the body caused by excess fluid in the tissues.

Encopresis--A condition in which children continue to soil their pants after toilet-training. Most children with this problem can be helped by physicians and psychologists.

Enuresis--A condition in which there is uncontrolled urination. In diurnal enuresis, wetting occurs during the day; in nocturnal enuresis, wetting occurs at night.

Etiology--The origin or cause of a disease.

Extension--A straightening of the trunk or extremities.

Fading--The gradual removal of discriminative stimuli such as cues and prompts.

Fine Motor--Movement that involves small muscles, e.g., grasping, writing, moving the toes.

Flexed (Flexion)--Inward bending of a joint, decreasing the angle; bending.

Gross Motor--Movement involving large groups of muscles, e.g., walking.

Hypertonicity--Excessive tension in the body of a muscle.

Hypertonus--Increased muscle tone.

Hypotonus--Decreased muscle tone.

Labyrinthine--Pertaining to the labyrinth in the internal ear comprising the semicircular canals.

Landau Reflex--An infantile, automatic posture in which the head and trunk extend when the baby is held in a prone position with the examiner's hands under the trunk.

Manual Dexterity--The coordination of the hands and fingers needed to complete the fine motor tasks.

Midline--The middle of the body; head in midline refers to the head in alignment with the spine.

Motor--Movement of muscles and joints.

Motor--Movement of muscles and joints.

Moro Reflex--The "startle" reflex seen in an infant lying on his back on a table when the table is struck on either side of the child.

Muscle Tone--Amount of tension in a muscle at rest.

Neurological--Pertaining to the normal and abnormal function of the nervous system.

Parachute Reaction--The automatic placing of hands on floor when infant is suddenly lowered from the prone position.

Passive--Movement controlled from the outside or done by someone else.

Positioning--the process of placing an individual into a position in which the body parts are in proper alignment to each other.

Pressure Areas--Red, swollen, and/or bruised spots on the skin surface.

Pronation--Turning downward, forearm palmdown.

Prone--Lying on stomach, face down.

Proximal--Nearest to the point of reference; opposite of distal or farthest from the point of reference.

Reflex--A habitual way of responding; ordinarily refers to inborn tendency for a part of the body to respond to a stimulus in a certain way; posture or movement not controlled by the individual.

Rigidity--Not being flexible or bending; stiff; hard.

Self-Care Skills--The ability to care for oneself; usually refers to basic habits of dressing, eating, etc.

Sensory Awareness--Ability to receive stimuli from the environment; visual, auditory, tactual, olfactory, taste.

Spinal Cord--That part of the central nervous system contained within the vertebral column.

Standing Table--A rectangular box that enables an individual who cannot stand without the support to bear weight on his legs and feet.

Static--No movement.

Stimulus--That which causes a response.

Supination--Turning of the palm or foot upward.

Supine--Lying on one's back, face up.

Symmetrical--Both sides equal.

Tactile--Sense of touch.

Task Analysis--Technique of examining a particular task to discover each individual part of it and the processes needed to perform it; the process of breaking down a task into small component parts.

Tendon--Attaches muscle to bone.

Tone--Degree of muscular tension.

Tonic Reflex--A reflex that lasts as long as body maintains a given position.

HEALTH RELATED IMPAIRMENTS:

Anchondroplastic Dwarfism--An inherited form of dwarfism or arrested growth. It results in overall smallness and espeically short upper arms and thighs.

Anemia--A condition in which there is an abnormal reduction in the number of red blood cells present in the blood.

Antibiotic--A substance prescribed by a physician or dentist to kill or slow the growth of certain bacteria. usually taken by mouth, antibiotics should always be taken for the prescribed length of time. There are no antibiotics that affect viruses.

Antibodies--Particles produced by the body to surround and destroy undesirable substances that enter the body, such as bacteria, viruses, molds, and pollen (which causes hay fever and other allergic reactions).

Anticonvulsant--A medicine used to control seizures. The amount to administer must be calculated on the patient's body weight.

Benign--Refers to a tumor or growth that can destroy tissue by pressing on it or by filling a body space required by another organ.

Bladder--The sac that holds the urine until urination can take place.

Carbohydrate--A food that provides energy. Normally obtained from sugar and creals.

Carbon Dioxide--The gas that is produced in body tissues as a waste product. It is removed from tissues by the blood. The blood then caries it to the lungs for exhalation.

Failure to Thrive--A situation in which a combination of health and/or psychological reasons results in a child's inability to gain weight and grow.

Familial Disease--Refers to an inherited disease or condition that runs in families.

Familial Dwarfism--An inherited form of dwarfism or arrested growth that results in overall smallness.

Fat--A food that supplies needed material both for body building and for energy.

Febrile Seizure--A seizure casued by a repidly rising fever. Febrile seizures are brief, and do not necessarily indicate that a child has epilepsy.

Focal Seizure--A type of seizure in which there is jerking in a single limb or one side of the body.

Functional murmur--See heart murmur.

Genes--The parts of teh chromosome that direct the way in which body tissue develops. For example, genes direct the shape of the nose and the color of the hair.

Heart Murmur--A sound made by the action of the heart when the valves between the heart chambers do not close completely. Functional heart murmurs are not harmful in any manner. Organic heart murmurs indicate serious problems.

Hemophilia--An inherited condition affecting males, in which the blood plasma contains an insufficient quantity of the factor needed to clot blood.

Hereditary--Refers to a disease or condition that is passed from parents to child.

Hydrocephalus--A condition in which the head is enlarged and the brain has excess fluid in the four ventricles (cavities) in the middle of the brain.

Hypoxia--A deficiency in the amount of oxygen reaching bodily tissues.

Insulin--The hormone required by the body for proper utilization of carbohydrates. Diabetics, who lack insulin, can be given insulin by injection.

Insulin Shock--A situation in which a diabetic receives too much insulin and then uses up all available carbohydrates. Insulin shock may be associated with seizures.

Jaundice--A yellowish tinge or color of the skin, usually caused by problems in the liver.

Leukemia--A condition in which there is an abnormal increase in the number of white blood cells present in the blood. Also called cancer of the blood.

Malignant--Refers to a tumor or growth that destroys other tissue as it grows. Usually means that the tumor or growth is cancerous.

Malnutrition--a chronic lack of essential food stuffs, which results in a

Megalencephaly--A condition in which the head is enlarged and the brain is enlarged and abnormal. Usually associated with mental retardation.

Metastatic--Refers to the spread of tumor cells to other parts of the body.

Microencephaly--A condition in whch the head and brain are significantly smaller than normal for age and sex.

Motor Cortex--The surface of the brain that controls the muscles of the trunk, arms, and legs.

Myoclonic Seizure--A type of seizure in which there are short, isolated jerks of the muscles.

Myringotomy--An incision made in the eardrum to drain fluid from an infected ear. In a myrongotomy and tubes, a small "bobbin" of plastic is inserted in the incision to allow air to enter the middle ear and assist in the drainage of fluid.

Neurocutaneous Syndromes--A group of conditions that combine skin and sensory or nervous difficulties.

Organic Murmur--See heart murmur.

Pigmentation--Coloration of the skin and eyes.

Pituitary Dwarfism--A form of dwarfism or arrested growth that is caused by failure of the pituitary gland. It results in overall smallness.

Platelets--Small particles in the blood that assist the blood in clotting.

Post-ictal Sleep--Sleep that follows an epileptic seizure. it is natural and should be allowed.

Primary Tumor--An original tumor (as opposed to a metastatic tumor).

Protein--A food that supplies the basic building materials required by the body. All children need adequate amounts of protein to assist in brain and body growth.

Psychomotor Seizure--A type of seizure in which the child displays inappropriate behavior for the setting and automatic or involuntary movements and actions.

Red Blood Cells (RBC)--The cells in the blood that carry oxygen to parts of the body where it is needed.

Rubella--German or three-day measles. Rubella is usually mild, but it can seriously harm a baby whose mother is infected early in her pregnancy.

Sex Linked Condition--A condition that is passed from parents to child through a sex chromosome. Mothers are carriers of teh condition without having it themselves. Examples include muscular dystrophy and hemophilia.

Shunt--A tube that is surgically placed between the ventricles (cavities) of the brain and other organs such as the abdomen. Shunts are used to drain excess fluid and pressure from the brain.

Status Epilepticus--A situation in which two major epileptic seizures occur, one right after the other. In such a case, immediate emergency room attention is required. Status epilepticus happens rarely.

Stoma--A surgical opening in the abdomen that allows drainage of either urine or stool into disposable bags.

Strep Sore Throat--A sore throat caused by streptococcal bacteria. It should be treated for a full ten days with an appropriate antibiotic.

Symmetrical--Having all parts evenly disributed.

Syndrome--A set of signs or symptoms that occur together repeatedly in a number of cases.

Thyroid Hormone--Produced by the thyroid gland in the neck, this hormone is required during all phases of development, but particularly during infancy.

Toxin--Any substance that acts like a poison.

Trachea--The windpipe, which leads from the back of the throat to the lungs.

Trauma--A blow or injury.

Upper Respiratory Infection (URI)--An infection of the ears, throat, and tonsils. Usually caused by a cold.

Ureters--The tubes that carry urine from the kidneys to the bladder.

Urethra--The tube that carries the urine from the bladder to the outside of the body.

White Blood Cells (WBC)--The cells in the blood that assist the body in preventing infection.

LEARNING DISABILITIES:

Aphasia--Loss of impairment of the ability to use words and to understand language symbols in reading, writing, or speaking. Usually results from brain injury or disease. Developmental aphasia usually results from brain injury or delayed development of the central nervous system.

Attending Behavior--The ability to pay attention to a task. Attending behavior includes alertness, stimulus selection, focusing, and vigilance.

Brain Injury--Injury or damage to some parts of the brain. Occurs before, during or after birth.

Cognitive Development--Cognition refers to the process of knowing. Cognitive development refers to the development of skills necessary for understanding and organizing the world, including such perceptual and conce3ptual skills as discrimination, memory, sequencing, concept formation, generalization, reasoning, and problem solving.

Developmental Aphasia--See aphasia.

Dyslexia--A term used by some physicians or reading specialists to describe specific disabilities in reading.

Form Constancy--The ability to recognize an object or shape, regardless of what position or angle it is viewed from.

Hard Signs--A term used by neurologists to indicate that a chld performs in an observably differnt way than the average child in certain central nervous system functions. These differences may be quantitative or qualitative. They may include the presence of inappropriate responses and/or the absence of appropriate responses.

Minimal Brain Dysfunction (MBD)--A medical term used to indicate a delay or disorder in the ability to perform sensory or motor functions appropriately.

Neurological Dysfunction--The inability to perform sensory or motor fucntions appropriately.

Perceptual Handicap--The inability to interpret stimuli received through the senses,, despite adequate vision, hearing, and other sensory processes.

Sensory Modality--Sensory modality refers to any one of the five sensory avenues for receiving information: seeing, hearing, touching, tasting, and smelling.

Soft Signs--A term used by neurologists to indicate that a child performs in a slightly different way than the average child in certain central nervous system functions. These differences may be qualitative or quantitative. The data relating soft signs to learning disabilities are more questionable than the data relating hard signs to learning disabilities.

Sound-Symbol Association--The ability to recognize sounds and their sources and to recognize the sounds that go with letters. Sound-symbol association is a prerequisite to reading.

BOOKS FOR USE IN CLASSROOMS TO FACILITATE DISCUSSION OF DISABILITIES

1. Behrens, June. 1976. Can You Walk the Plank? Children's Press, Chicago, ILlinois. A book with photographs exploring basic movement skills through such fantasy experiences as walking the plan (blanace beam).

2. Brightman, Alan. 1976. Like Me. Little, Brown, and Company, Boston. A child looks at his mentally handicapped friends and points out that everyone is the same although some people are slower at learning.

3. Castle, Sue. 1977. Face Talk, Hand Talk, Body Talk. Doubleday and Co., Garden City, New York. How chldren can say things and express feelings using only their bodies and faces.

4. Cohen, Miriam. 1967. Will I Have a Friend? Macmillan Publishing Co., Inc., New York. The first day of school concern with finding a friend.

5. Fassler, Joan. 1975--3rd printing 1978. Howie Helps Himself. Albert Whitman and Compnay, Chicago, Illinois. A child with cerebral palsy wishes to move his wheelchair by himself.

6. Glazzard, Margaret H. 1978. Meet Lance. He's a Special Person. H and H Enterprises, Inc., 946 Tennessee, Box 1070, Lawarence, Kansas. A story about a boy with Down Syndrome and how he learns.

7. Green, Olary Olc Burney. MCMLX. Is It Hard? Is It Easy? Addison-Wesley Pusblishing Compnay, Inc., Reading, Massachusetts. Points out everday tasks that may be hard or easy for different children.

8. Hirsch, Karen. My Sister, Carolrhoda Books, Minneapolis, Minnesota. A child's perception of her retarded sister as a very special person.

9. Kraus, Robert. 1971. Leo the Late Bloomer, Windmill Bookds and E.P. Duton, New York. The fantasy story of a tiger, Leo, who is a slow learner but finally "blooms".

10. Lasker, Joe. 1974. He's My Brother, Albert Whitman and Company, Chicago. A young boy describes the experiences of his younger brother who has a learning disability.

11. Mack, Nancy. Tracy, Raintree Editions, Milwaukee, Wisconsin. A photo story of a girl who has cerebral palsy.

12. Ominsky, Elaine. 1977. Jon O: A Special Boy, Prentice Hall, Inc. Englewood Cliffs, NJ. the life of a boy with Down Snydrome who hs adjusted to being a very special child.

13. Peterson, Jeanne W., 1977. I Have A Sister, My Sister Is Deaf. Harper-Row, New York, NY. An illustrated story of how a deaf sister experiences everyday life.

14. Simon, Norma. 1976. Why Am I Different?, Albert Whitman and Company, Chicago. Discusses everyday situations in which chldren see themselves as "different" in family life, preferences, and aptitutdes, and yet, feel that being different is all right.

15. Simon, Norma. 1970. How do I Feel? Albert Whitman and Company, Chicago. A book about feelings of children--anger, frustration, weariness, pride, etc.

16. Stein, Sara Bonnett. 1974. About Handicaps: An Open Book For Parents and Children Together, Walker and Company, New York, NY A boy learns about physical handicaps of others, including a child with cerebral palsy. This book includes a text for parents or teachers.

17. Wolf, Bernard. Anna's Silent World, Lippencott Publishing. A photographic description of a deaf child's life.

FILMS/VIDEOS REGARDING HANDICAPS

"Cry Sorrow, Cry Hope" (Beta, VHS or 3/4 U-matic) is a 55 minute film portraying the frustrations and emotional difficulties of the Fisher family, who suspect their chld Billy s mentally retarded, and finally have the chid evaluated. The film very graphically demonstrates a pilot parent in action and what the program is attempting to accomplish, in the person of former US Attorney General Ramsey Clark, who has a retarded daughter. The information and support he gives to Mr. Fisher is an excellent example of pilot parenting.

The film "Cry Sorrow, Cry Hope" depicts the impact of one particular handicap--mental retardation--upon the Fisher family. However, the initial feelings of loss, anger, and guilt are common to parents of children with all handicaps. Thus, the film adequately meets the needs of demonstrating what a pilot parent does.

"A New Set of Fears, A New Set of Hopes" (3/4 and 1/2 formats, 33 minutes) Pilot Parent Program. A videotape portraying a family's feelings, frustrations and hopes as they adjust to life with their son who has Down Syndrome. Available through Media Resource Center, MCRI University of Nebraska Medical Center, 444 South 44th St. Omaha, NE 68131 (402)550-7467.

"Sharing the Experience With Peter" (16 mm, Approximately 30 minutes) Pilot Parent Program. A family's love, their struggles and concerns for their severely handicapped son. It also shares a program within the community to bring families together to make new friends. Good teaching film on normalization. Peter is a young boy who is severely handicapped and has very little speech. He also has a delightful sense of humor and a new way to communicate.

Peter is very much a part of his family. His two brothers and his parents, Janet and Jerry, share with the audience their love for him, their struggle to have him accepted by his community, and their concerns for his future. The audience also learns of a new program in Peter's neighborhood. It is called "Extend-A-Family" and brings families together to make new friends. By helping friendships form between handicapped and non-handicapped children, "Extend-A-Family" opens up to the community so that all children have a place.

This film can be purchased through Publication, The Canadian Association for Mentally Retarded, 4700 Keele Street, Downsview, Ontario, M3J 1P3, (416)661-9611, for $2.00. For US order contact the Stanfield House, P.O. Box 3208, Santa Monica, California, 90403, (213)820-4568.

"I'm Not What You See" (16 mm, Approximately 30 minutes) Just Friends. Purchased from Filmmakers Library, Inc.

"David" (16 mm, Approximately 28 minutes) Just Friends. Purchased from Filmmakers Library, Inc. Documentary film about David McFarland an articulate personable 17-year-old with Down Syndrome. His rich and varied life in his community including learing role in a TV drama is shown.

"Exploding the Myth" (16mm, Approximately 30 minutes) Just Friends. Purchased from Lawren Productions, Inc. "Exploding the Myth" is a dramatic investigation into attitudes currently held by a significant portion of the public regarding mentally handicapped people. The film highlights, then shatters, misconceptions that have persisted through the history of man's treatment of mentally retarded people. By attacking these myths with truth and reality, it is hoped that barriers built from superstition and ignorance will give way to community understanding and accpetance of mentally retarded people.

Directed with sensitivity, the film is at times brutally frank. Mentally retarded people clearly demonstrate their biggest problem is not intrinsic to the condition of mental retardation, but is intrinsic to the human nature of those around them.

"Board and Care" (16 mm, Approximately 27 minutes) Just Friends. Purchased from Pyramid films. The purpose is to show that although a person may be intellectually retarded, they still have a full emotional capacity for love, loneliness, freindship and frustration. This sensitive short story focuses on the desires of two retarded teenagers for a meaningful relationship. During a chance encounter Ricky, a young famr boy and Lila, a girl enrolled in a nearby special program, are attracted to one another. Their friendship deepens during a community picnic but the two young people are soon separated by circumstances and the plans of their adult guardians.

"Sharing the Experience with Gavin" (16mm, Approximately 30 minutes) Pilot Parent Program. Gavin can be purchased thrugh Publication, the Canadian Association for the Mentally Retarded, 4700 Leele Street, Downsview, Ontario, N3J 1P3, (416) 661-9611. For US orders contact: The Stanfield House, P.O. Box 3208, Santa Monica, California, 90403, (213 820-4568. film describing a near-ideal situation where the birth of a hanciapped child with Down Syndrome resulted in the hospital and community working closely to give the child and his arents the best start in life.

When Gavin was born, he was discovered to have Down Syndrome. From the moment of his birth his parents, Sylvia and Scott, received all the information and support they needed to understand and adjust to the news of their young son. In a very peronal and intimate fashion, Sylvia and Scott described the birth experience; their decision on amniocentesis and future children; and concern about being free to enjoy Gavin as a delightful addition to their family.

Also shown is one of the more personal services available to families--"Pilot Parents". This vital parent-to-parent support allows experienced parents of handicapped children to guide new parents. The benefits are mutual.

"Nicky: One of My Best Friends" (16 mm., 15 minutes) Just Friends. Purchased from McGraw-Hills Films. Nicky Sarames was born blind and with cerebral palsy. His parents, wishing him to be accustomed to "normal" life as soon as possible, enrolled him in a regular public school class. "Nicky: One of My Best Friends" is an authentic, unrehearsed documentary of a typical school day in Nicky's life. His success in the mainstream is due to a combination of factors shown in the film.

Nicky's family provide love and concern without being over-protective. The boy and his family are seen together as Nicky prepares for school and as he discusses an achievement test with his sister at the breakfast table. After being driven to school by his parents, Nicky makes his way alone to his first class. He is not afraid to be on his own, and achieve a high degree of self-sufficiency.

The commitment of Nicky's school to the mainstreaming effort also helps to make his education a success. Special materials, techniques, and personnel are provided to enable him to participate as fully as possible in day-to-day classroom activities. Much of his classwork is prepared in braille. His resource teacher meets with him regularly and is responsible for individualizing his school program. Regular classroom teachers have found ways to make Nicky a productive member of a group. While other students make cardboard models in social studies class, Nicky tapes records of a hypothetical interview with a famous historical character.

NICHCY

NATIONAL INFORMATION CENTER FOR HANDICAPPED CHILDREN AND YOUTH

P.O. BOX 1492 WASHINGTON, D.C. 20013

NATIONAL TOLL-FREE NUMBERS

AT & T National Special Needs Center	800-222-4474 800-233-1222 800-833-3232 (TDD)
Alzheimer's Disease & Related Disorders	800-621-0379
AMC Cancer Information Center	800-525-3777
American Cleft Palate Educational Foundation CleftLine Center in Pennsylvania	 800-24-CLEFT 800-23-CLEFT
American Council of the Blind	800-424-8666
American Foundation for the Blind	800-AFBLIND (232-5463)
American Kidney Fund	800-638-8299
American Tuberous Sclerosis Association	800-446-1211
Association for Retarded Citizens of the U.S.	800-433-5255
Association of Heart Patients Heartline	 800-241-6993
Better Hearing Institute Hearing Helpline Center in Northern Virginia	 800-424-8576 703-642-0580
Cancer Information Service National Line	 800-4-CANCER
Captioned Films for the Deaf	800-237-6213
Center for Special Education Technology Center in Northern Virginia	 800-345-TECH 703-620-3660
Cornelia de Lange Syndrome Foundation	800-223-8355
D. T. Watson Rehabilitation Hospital	800-223-8806
Educators Publishing Service, Inc. Specific Language Disabilities (Dyslexia) Center in Massachusetts	 800-225-5750 800-792-5166

Epilepsy Foundation of America	800-EFA-1000
Epilepsy Information Line	800-426-0660
ERIC Clearinghouse on Adult Career and Vocational Education	800-848-4815
Higher Education and the Handicapped (HEATH)	800-54-HEATH
Insurance Hotline	800-423-8000
International Shriners Headquarters	800-237-5055
Job Accommodation Network (JAN) Center in West Virginia	800-526-7234 800-526-4698
Job Opportunities for the Blind (JOB)	800-638-7518
Juvenile Diabetes Foundation International	800-223-1138
Lung Line (lung disorders, allergies)	800-222-LUNG
National Adoption Center	800-TO-ADOPT
National Association for Hearing and Speech Action	800-638-TALK (Voice or TDD)
National Association for Sickel Cell Disease, Inc.	800-421-8453
National Captioning Institute	800-528-6600
National Center for Stuttering	800-221-2483
National Center for the Prevention of Sudden Infant Death Syndrome	800-638-7437
National Committee for Citizens in Education	800-NETWORK
National Crisis Center for the Deaf Center in Virginia	800-446-9876 800-552-3723
National Cystic Fibrosis Foundation	800-344-4823
National Downs Syndrome Congress	800-232-NDSC
National Downs Syndrome Society	800-221-4602
National Easter Seal Society	800-221-6827
National Hearing Aid Society	800-521-5247
National Information Center for Educational Media	800-421-8711

National Organization on Disability	800-248-ABLE
National Parkinson Foundation	800-327-4545
National Rehabilitation Information Center	800-34-NARIC
National Spinal Cord Injury Hotline	800-526-3456
National Tuberous Sclerosis Assn., Inc.	800-CAL-NTSA
Occupational Hearing Services (O.H.S.)	800-222-EARS
Office of Health Promotion & Disease Prevention Health Information Center	800-336-4797
Orton Dyslexia Society	800-222-3123
RP Foundation Fighting Blindness	800-638-2300
Special Education Software Center	800-327-5892
Spina Bifida Hotline	800-621-3141
Tripod-Service for Hearing Impaired	800-352-8888

This information sheet was developed by Interstate Research Associates, Inc. pursuant to Cooperative Agreement #G0084C3500 with Special Education Programs of the U.S. Department of Education. The contents of this publication do not necessarily reflect the views or policies of the Department of Education, nor does mention of trade names, commerical products or organizations imply endorsement by the U.S. Government.

This information is in the public domain unless otherwise indicated. Readers are encouraged to copy and shared it, but please credit the National Information Center for Handicapped Children and Youth.

REV.
12-23-86

IOWA'S AREA EDUCATION AGENCIES